AZ HIPAA Medicaid Consortium

Aug 13, 2003
2:00 PM to 4:00 PM
AHCCCS 701 E. Jefferson St. – 3rd Floor - Gold Room

Meeting Hosted By: Lori Petre, AHCCCS

Attendees:

ADHS	**APIPA**	**HCA**
Thomas Browning	*Sharon Zamora*	*Paul Benson*
Brian Heise	*Lucy Markov*	*Ethan Schweppe*
AHCCCS	**BHS**	**HCSD**
Kathy Bezon	*Jan Hippe*	*Michael Wells*
Lydia Ruiz	*CJ Major*	**I.H.S.**
Matt Furze	**Care 1st Arizona**	*Charolett Melcher*
Bruce Jameson	*Herb Woo*	**MCP & Schaller Anderson**
MaryKay McDaniel	*Terry Harden*	*Cathy Jackson-Smith*
Linda Stubblefield	*Bill Hobbs*	*Anne Romer*
Tom Forbes	**CHS**	*Art Schenkman*
Gary Heller	*Susan Speicher*	**Maricopa Health Plan**
Brent Ratterree	*Anna Holland*	*Rob Mayer*
Peggy Brown	**CRS**	**Pinal LTC**
Deborah Burrell	*No Rep signed in*	*Susan Murphy*
Nancy Mischung	**CIGNA**	**PHP**
Frank Straka	*No Rep signed in*	*JoAnn Ward*
Dennis Koch	**DES/DDD**	**PHS**
Sandy Biggs	*Marcella Gonzalez*	*Mark Hart*
John Peters	*Stan Hime*	**UFC**
Mariaelena Ugarte	*Major Williams*	*Eric Nichols*
AmeriChoice	**Evercare Select**	*John Valentino*
Beth Ptak	*Vicki Johnson*	**Verizon**
Schemell Moore		*No Rep signed in*
Dana Embery		**Yavapai County**
		David Soderberg

1. Project Schedule Update (Gary Heller)

Milestones reviewed:
Milestone schedule changes made were:

- Draft vs. Final Companion Doc dates added.
- Transactions split differently between Group 1 (820/834), Group 2 – Providers and Clearing houses; Grp 3 – Encounters
- Implementation dates, as well as other key dates were added.

Suggestions or questions are welcome. This is intended to be a general overview of where we are and were we intend to be on each transaction.

Q: Date on first 834 Monthly?
A: We will discuss this and get a consensus on which dates will make most sense to reflect in the document.

Guide to HIPAA Compliance:
Handout is an overview of the compliance strategy that CMS is following. CMS is looking for good faith efforts; corrective action plans to get either to the mandated dates or corrected dates.

2. Follow-up Items (Lori Petre):

Local Codes (Brent Ratterree):
Only three codes are outstanding from CMS. All reference changes are implemented.
One with LTC behavioral health with personal care, rate issue. Another Mileage codes for Transportation, recommendation to follow in the next couple of weeks.
We will let you know when we have a firm date of when you can see the Reference and Provider files.
Action – Dates to be included in the minutes
Result: The September provider and reference files will have the expected changes.

Encounter Delay (Lori Petre):
Last meeting we walked through the dates associated with Encounters. If you have any questions please let us know.

Acknowledgement Flows (Lori Petre):
The final acknowledgement flows for the 834/820 have been sent out. We are reevaluating the flows for our 837 providers.

Q: 834 Acknowledgement flows, interpretation of the IG, if you are requiring a stamp that correlates to what the 997 is responding, then our take is that it makes a 997 not following the standard format.
If we or anyone comes up with a new version of a 997, then we will be in trouble, since that tells the translator what version we are working with.

This is the issue with a 4010, where the X12 workgroup 8 came out with a recommendation. The recommendation is to use the larger number, since you are telling someone what you are responding to.

This also tells your translator what version you are using.
Then this is a GS08 issue.
Action Item: MaryKay will look into this.

The Interchange control number from the document sent originally to us. I do not see where to send the control number, no ISA number.
Q: How do you connect the associated file to the 997 file?
A: A possible solution is naming the 997 file going back with a similar name having the contents of a 997.

The acknowledgement 997, cannot tell what ISA goes with it. We need the ISA control number to be able to identify what file its in.
This is an X12 issue; it is a shortcoming of the 997.
We were hoping to use a TA1 instead.
Action: Mary Kay and Lori will research this issue a little more, and discuss it as an agenda item in the next meeting.

Data Certification (Brent Ratterree):
IT is looking at some recommendations and starting some proposals.
We will start with a manual process at first. Will happen later this year. We are looking at an automated process to allow the system to process the files.

We anticipate the automated solution happening with Encounters in January 2004.

3. Implementation Planning Update (Jim McManus)

September 19th we will promote changes related to co-pay.
The co-pay notifications will be mailed September 24th.

834/820 HIPAA Monthly/Daily files:
The last daily in September and first monthly in October will be in the 834 format.
Recently we have clarified that the last daily of September has to be an 834.
September 26th is the last old format daily roster.
Then we will begin with critical path and promotes for HIPAA.
This will run through September 28th, the last daily will be dated September 27th, and available on September 28th.

September 28th will run the monthly roster for October and should be completed September 30th.
Available for pickup September 30th.

We will get into the first daily for October, including 9/28, 9/29, 9/30 and dated 10/01.
Then a normal cycle processes.

Action Item: Clarification will be added to the document. Will be distributed with the minutes, and discussed again at the next meeting.

The first 820-capitation remittance should be available 10/02 or 10/09.
Action Item: We will clarify the capitation payment date as soon as we get direction from Finance.

Q: Which enrollment period will the 820 be for?
A: Finance pays in advance when we run the payment cycle. When we run the 820 it will run for the Wednesday for the week prior.

For example: Capitation payments week of the 24th through the 30th will be paid October 2nd.

Action: Frank will document this process, and it will be sent out with minutes or distributed in our next meeting.

We will promote the 270/271 on October 1. When this happens the co-pay information will be available on our Web site also.

Related to the co-pays, the co-pay should appear first on the last daily roster in the new format.

Q: Hospital kicks? NPR files after September 27?
Action: We will look into this and send response.

4. Testing Status (Lori Petre)

Graph handout is as a result of the feedback we are receiving to the emails regarding testing participation.

MCO problem report matrix sent out Mondays and is also on the Web site for viewing.

Testing Expectations for the month of September:
We had some internal meetings, and have a few things we'd like to accomplish after B2B testing.
We want to give our Operations an opportunity to run the new translator and changes through the first several weeks of September, as indicated in the Calendars handed out.
We want to make sure that we can produce new and old rosters, depending on who needs to have them, to test contingencies.
During this time you will not receive an 834 everyday, we will not parallel production. It is a different testing window. This is your window of opportunity were we get you co-pay tests, or special scenarios can be created.

Q: Companion document has not been updated with this co-pay yet?
A: We just received the request and it will be reflected in both the 270 and 834 Companion Documents.

5. Encounters Design Discussion and Example (MaryKay McDaniel)

Required health plan Ids and 837 Encounters:
This is managed differently from 837 claims.
For those submitting encounters it will be a health plan id, 3 byte TSN and an input mode, input mode being a 2 for a regular adjudicated encounter or a 6 for denies. Files will be split, denial in one regular adjudicated encounter in another. If you mix them then the denials they will go through the regular encounter process, i.e., all edits and audits.
You are required to keep denials separate from the regular encounter process.

The places we expect to see a 10-byte field is the submitter, 1000A, 2320 loop, and the 2420.

The TSN will be split by site for CRS; and clinic for RBHAS (BHS).

The picture handed out is a representation of what an 837 is expected to look like, it is a draft and is open for suggestions within the next two weeks.

Professional:
On the professional the 1000A is always going to be the health plan, CRS, BHS, or DES DD and the receiver is going to be AHCCCS.
In the 1000A NM109 we are expecting that 10-position field.
The choice whether it was a denial or a regular adjudicated file was unanimous not to change submitter id numbers, therefore we dropped it down into the transaction itself.

The 2000A Billing provider level was who was paid by the health plan for the service. It is the highest-level tax id.

The 2300 loop is claim information also known as the header information.
The 2305 is not expected and can be accepted if you send it.
The 2310B will be the clinic or the provider who has the AHCCCS id to provide the service.

If an individual physician provides the service it will be his AHCCCS id that is provided there.
Coordination of benefits information is expected to be at the line level 2420 not at 2320 level.
The provider sends a remit with a lump sum at the header level needs to be broken down by line.

The 2320 will have at least one loop for the health plan. If MCP pays a claim where there was Medicare prior to that, then there will be two 2320 loops, one for the plan and one for Medicare.

The 2400 is the service line information.
The 2430 SVD01 is the key to that adjudicated line that tells us who paid that claim and how.
If Medicare had paid a claim and MCP then we expect two loops one MCP and one Medicare.
The health plan must provide how the claim was paid, even if it is 0.

For us to figure out the Health plan payment we identify who the Health Plan was and get the actual payment amounts, everything else is considered as Other payer payment amounts.

The hp paid amounts are a required field.

Action: We will need to put adjustment reason codes meaning what you paid and why you paid.

If we are not told that you paid 0 then the encounter will pend.

Dental:
The NM109 on the 1000A will need to be a 10 byte,
One 2320 loop representing a health plan.
We would like to see all of the payment at the line level rather than at the claim header level.
The 2430 first position, there will be one showing how the health plan paid it.

Q: How many health plans will allow in system line level providers different from the header level provider #? Can you adjudicate that claim? (Consensus from Health Plans – they cannot.)
A: From an encounter perspective then we will not look at getting different providers at that line.
That is five additional id numbers that may need to be carried at the line level.

AHCCCS can capture this information but not adjudicate it.

Action: Follow-up of provider number at line levels. Mary Kay or Lori?
Result: Completed by Mary Kay.

Institutional:
Submitter identification number needs to be a 10-position field.
The billing provider is the same, with highest tax id.
2320, one loop will have to be the health plan.
2430, we will expect to see one loop for each line if you value at the line, such as in outpatient or outlier, else at the header.

Q: Are you looking for a loop on each line?
A: If you value each line.

If you noncover or disallow days on a patient you will need to report this as well at the header.

When encounters are certified and processed then a 277 unsolicited will come back.
There is a crosswalk handout – It is a current file received today and cross-walked to where you will see that information on the 277U.
The one piece you will not get is the health plan claim number.
Today it is sent in the patient account number field, and the 277 does not allow a place for a one for one CRN number. There is no responding health plan claim #.

Q: Does the patient acct field have to reflect the patient acct?
A: Yes, it helps in the validation audit.
An option we have is to build an additional 22XX loop.

We can create an additional loop and send it back. Issue would exist with a 2200 loop with AHCCCS information and a 2200D loop that has your health plan information and then you will need to try and put these loops together.

Q: This is a large issue, how will we be able to track this?

Q: If we embed our patient account number in this field?
A: Recommendation is to create 2 loops.

Q: Will we get the 2200D loop in pairs?
A: Yes, they should always fall this way.

We will have adjacent records just based on their placement or physical proximity.

Pg5. You can have a transaction segment and at the bottom of PG 6, the second loop would be identical to the first.
One will have the AHCCCS CRN and one the claim number.

Q: Have you tried putting one of these through Claredi yet?
A: Not at this point.

There were multiple qualifiers and one said, “claim number” or “submitter number”. If there were lines that went with it, you would also get the line information.

1K is the only option. 1K means ‘Payers claim number’. You can repeat that loop twice.

Segment summary sheets information is available in the Implementation Guide.

Q: No form type field on U277? How will we handle this?
A: There is no form type on the U277, suggestion is from the claim number sent back on that second loop.

Q: We are doing the U277 because?
A: It is a standard transaction that will be in place within the next year to two.

Q: If this is not adopted yet then why are we doing this?
A: We are trying to move all our transactions to a standard format.

Q: Since this U277 potentially affects our business, why are we doing this?
A: To move towards a standard transaction.

Some contractors use the patient account number field as patient account number and other claim numbers.

The issue helps identify claims easier than they are identified now.

Suggestion: If you are sending AHCCCS an internal claim number there is nothing saying that you can’t embed a form type along with that claim number.

Another issue came up to have more flexibility in implementing the different formats.

This U277 is slated for the February cycle, giving the health plans an additional 30 days.

Q: I do not show the RI case number translating over.
A: That is a True statement.

Q: Why are we doing this?
A: They are looking to standardize all transactions.

We will discuss the U277 in our next meeting. Please submit your questions or concerns.

Two things to think about for our next meeting:
1. NCPDP
2. Compound drugs – 5.1 allows reporting a compound biologic on a 5.1, therefore from a health plan perspective would you allow the biologic separate, one line separate biologics. If so will you send that as an encounter? Or will you only allow the compound drug as it is today?
A: We cannot answer this yet.

Suggestion: Walgreens often times has a test file that they use to test with their PBM, ask that they send you a test file.

6. Other (Lori Petre/ Group)

Status report on current Claredi tickets is in the handouts. They are all resolved. Both the 834 and 820 were certified and will be recertified if any changes necessitate this.
Action: Current status will be sent out.
Result: Item posted to the WEB along with other handouts provided at today's meeting.

Open item: CMS testing status – email sent requesting status and another will be sent to those who have not replied.

Reminder: Think about what special scenarios you would like tested in September's window.

August 27th is the next meeting.

Meeting adjourned.